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	17E294	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS75108.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: The facility reported a census of 31 residents. The sample was 3 residents. Based on observation, interview and record review the facility failed to notify the physician of bruising for 1 (#2) resident that received Coumadin (a medication used to decrease blood clotting). Findings included: - Review of the Admission Minimum Data Set (MDS) for resident #2 dated 7/10/13 revealed a Brief Interview for Mental Status (BIMS) score of 5 which indicated severe cognitive impairment. Review of the cognitive loss Care Area Assessment (CAA) dated 7/10/13 revealed the resident had periods of confusion. Review of the behavior CAA dated 7/10/13 revealed the resident had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), hallucinations (sensing things while awake that appear to be real, but the mind created), suspicion and paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking). Review of the fall CAA dated 7/10/13 revealed the resident liked his/her independence, and did not call for help, occasionally would slip from edge of bed or wheelchair to floor. The resident did not respond well to reminders to call for or wait for help. Review of the quarterly MDS dated 4/2/14 revealed a BIMS score of 6 which indicated severe cognitive impairment. The resident was usually understood, understood others, and had delusions. The resident was independent for mobility, transfers, walking in the resident's room,	F 157		

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F 157	Continued From page 2 dressing, and toileting. Review of the revised care plan dated 4/16/14 for anticoagulation (a medication used to decrease blood clotting) revealed staff were to notify the physician for signs and symptoms of unusual bleeding or bruising. Review of the physician's order dated 5/15/14 revealed the resident was to receive Coumadin (anticoagulant) 7 milligrams daily. Review of the nurses' note dated 5/3/14 at 11:00 P.M. the staff found the resident on floor in front of the closet in the sitting position. Review of the nurses' note dated 5/5/14 at 8:10 A.M. revealed the resident had 5 centimeter (cm) x 4 cm raised brownish/yellow bruise to the right forehead area. The resident denied pain, range of motion (ROM) was within normal limits, vital signs were within normal limits, and the resident did not remember hitting his/her head. Observation on 5/28/14 at 12:10 P.M. revealed the resident sat in the wheelchair in the dining room; the resident had bruising from the right scalp area, across the right eye and right cheek. A large bruised bump approximately quarter size in diameter, rose ¾ inches and was located on the right forehead. Interview on 5/29/14 at 12:25 P.M. administrative staff C stated he/she was unable to determine if staff notified the doctor of the bruising to the resident's forehead. The facility failed to notify the physician in a timely manner of bruising to the face for this resident that received coumadin.	F 157		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

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comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 31 residents. The sample included 3 residents. Based on observation, interview and record review the facility failed to update and individualize care plans for falls for 2 (#2, #3) of 3 residents reviewed for falls.

Findings included:

- Review of the Admission Minimum Data Set (MDS) dated 7/10/13 for resident #2 revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment.

Review of the Quarterly MDS 3.0 dated 4/2/14 revealed a BIMS score of 6, which indicated severe cognitive impairment. The resident was

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usually understood and understood others, and had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). The resident was independent for mobility, transfers, walking in the resident's room, dressing, and toileting.

Review of the cognitive loss Care Area Assessment (CAA) dated 7/10/13 revealed the resident had periods of confusion.

Review of the behavior CAA dated 7/10/13 revealed the resident had delusions, hallucinations (sensing things while awake that appear real, but the mind created), suspicion and paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking).

Review of the fall CAA dated 7/10/13 revealed the resident liked his/her independence, and did not call for help, occasionally would slip from edge of bed or wheelchair to floor. The resident did not respond well to reminders to call for or wait for help.

Review of the Care Plan update for falls revealed the record lacked documentation of a fall on 5/3/14 and no intervention was initiated to prevent additional falls.

Interview on 5/29/14 at 12:25 P.M. administrative licensed staff C stated there should be an entry on the care plan update for falls for each fall.

Review of the nurse's notes dated 5/3/14 at 11:00 P.M. staff found the resident on the floor in front of his/her closet in a sitting position.

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Observation on 5/28/14 at 12:10 P.M. revealed the resident sat in the wheelchair with a large bruise noted to the right side of the face.
Observation on 5/28/14 at 3:00 P.M. the resident sat in the doorway of his/her room. A large raised area noted to the forehead, approximately one inch in elevation, with discoloration of the resident's scalp which included the area around the resident's eye area and cheek, and a large raised area noted to the right upper shin on the leg and to the ankle area.
On 5/29/14 at 8:15 A.M. the resident rested in bed with the door to the room nearly closed.

Interview on 5/28/14 at 3:00 P.M. the resident stated he/she fell when he/she got the ladder out and climbed up to get something out of his/her closet at bedtime about 2 weeks ago. The ladder was in the apartment in a different room.

On 5/29/14 at 10:13 A.M. licensed staff E stated the care plans and the care plan update for falls were updated for falls with a new intervention.

Interview on 5/29/14 at 11:38 AM administrative licensed staff C stated comprehensive care plans were developed by the MDS coordinator and care plans were updated by the nursing staff.

Review of the Comprehensive Care Plan policy provided by the facility revised 10/10 revealed the staff were to do assessments of the resident and care plans were revised as the resident's condition changed.

The facility failed to update this cognitively impaired resident's care plan to include all falls and include timely and measurable interventions.

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- Review of resident #3's significant change Minimum Data Set (MDS) 3.0 dated 7/23/13 revealed a Brief Interview for Mental Status (BIMS) score of 2 which indicated severe cognitive impairment.

Review of the quarterly MDS 3.0 dated 4/16/14 revealed a BIMS score of 3 which indicated severe cognitive impairment. The resident had unclear speech, usually understood, and sometimes could be understood by others, The resident required extensive assist of one staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The resident was not steady and able to stabilize with staff for moving from seated to standing, walking, moving off and on toilet, and surface to surface transfer. The resident had impairment on one side of his/her body, and used the walker and wheelchair for mobility.

Review of the Care Area Assessment (CAA) dated 7/23/13 for cognitive loss revealed the resident had aphasia (condition with disordered or absent language function and responded with few words).

Review of the CAA dated 7/23/13 for falls revealed the resident was a high risk for falls due to partial foot amputation in the 1960's, a history of depression, and an orthotic shoe for the right foot. The resident used a pummel cushion (a chair cushion with a raised area between the thighs) in the chair to discourage standing without assistance, a floor mat next to the bed, and quarter side rail to assist with repositioning.

Review of the revised care plan for falls dated

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5/8/14 revealed the resident was encouraged to spend time by the fireplace in the recliner between meals for increased monitoring to prevent falls, staff were to continue to reposition and offer toileting every 2 hours, appropriate footwear when up and with ambulation, bed controls were moved to the bottom outside of the bed, staff were to check the position of the bed, and fall mats in front of the toilet.

Review of the care plan update of falls dated 5/10/14 revealed staff were to attach the personal alarm so the resident could not reach and remove it, accompany the resident for toileting, decrease the time the resident stayed in bed, a bed alarm, encourage this (cognitively impaired) resident to use the call light, wear non-skid socks at all times, and to toilet the resident more often.

Review of the revised care plan for falls and the care plan update for falls lacked direction for checking the placement and functioning of the alarm.

Review of the care plan update of falls lacked documentation for the falls on 3/24/14 and 5/15/14 and lacked new interventions for the prevention of falls.

Observation on 5/28/14 at 11:05 A.M. revealed the resident was in bed, the bed was in the low position, a fall mat was next to the bed, and a personal alarm was at the head of the bed.

Observation on 5/28/14 at 11:39 A.M. revealed the resident sat in the wheelchair in the dining room and a personal alarm was attached to the resident's shirt and the wheelchair.

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F 279	Continued From page 8 Observation on 5/29/14 at 7:30 A.M. revealed the resident sat in the wheelchair in the dining room. A personal alarm was attached to the resident's shirt on the right shoulder and the wheelchair. Observation on 5/29/14 at 11:09 A.M. revealed the resident was in bed and a personal alarm was located above the pillow at the head of the bed. Interview on 5/29/14 at 12:25 P.M. administrative licensed staff C stated there should be an entry on the care plan update of falls for each fall. On 5/29/14 at 11:38 AM administrative licensed staff C stated comprehensive care plans were developed by the MDS coordinator and care plans were updated by the nursing staff. Review of the Comprehensive Care Plan policy provided by the facility revised 10/10 revealed the staff were to do assessments of the resident and care plans were revised as the resident's condition changed. The facility failed to update this cognitively impaired resident's care plan to include all falls, direction for staff for the use of the personal alarm and include timely and measurable interventions after each fall for the prevention of further falls.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 31 residents. The sample included 3 residents. Based on observation, record review, and interview, the facility failed to review and revise a fall care plan for 1 (#1) resident of the sample.

Findings included:

- The significant change in status Minimum Data Set dated 3/25/14 for resident #1 revealed a Brief Interview for Mental Status score of 0 (severe impaired cognition). The resident required extensive assistance of two plus (2+) persons with bed mobility, transfers, walking in her/his room, and toilet use. The resident also required extensive assistance of one person for locomotion on the unit, dressing, personal hygiene and total dependence of one person physical assist with bathing. The resident was not steady and was only able to stabilize with nursing

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staff assistance when moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface to surface transfer. The resident had no functional limitations in her/his range of motion and used a walker and wheelchair (w/c) for mobility. The resident had two or more non-injury falls since admission/entry or re-entry or prior assessment.

The fall Care Area Assessment dated 3/25/14 revealed the resident required nursing staff assistance with transfers, toileting, walking, and was not safety conscious due to her/his altered thought processes. The resident was at risk for falls and had two falls. The resident had difficulty with sitting balance would bend forward at the waist. Most of the falls happened when she/he attempted to transfer self, or to walk alone. The resident had a pommel cushion (a cushion with an upward-projecting protuberance at the front part to prevent a resident from slipping down on the seat) in the w/c which kept her/him from sliding or falling forward but became strong enough to stand up beyond the cushion. Her/his ambulatory abilities varied throughout the day. She/he did not always use her/his walker, and had a cushioned landing pad, for falls from or by the bedside.

The revised care plan dated 4/10/14 listed the interventions: nursing staff would maintain the resident's eye glasses in clean working order and provide the eye glasses to her/him daily during waking hours, family provided a bed/chair alarm and nursing staff would respond immediately to the resident's alarm when sounded, would consistently note resident's whereabouts for safety reasons, assist the resident outside when

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weather permitted, and provided non-slip shoes or grippers socks.

The revised care plan dated 4/10/14 lacked documentation the resident's bed was placed in a low position, border air mattress, landing mats were placed on both sides of the resident's bed, and the chair/bed alarms were checked for function on every shift and documented on the Treatment Administrative Record (TAR).

Observation on 5/28/14 at 1:05 P.M. revealed the resident laid in the bed with the bed in low position, a border air mattress was in place, and the call light was within reach. Direct care staff G pulled the bedding a side and the resident laid on a white plastic alarm pad.

Observation on 5/29/14 at 7:15 A.M. revealed the resident laid in a low positioned bed with a border air mattress, call light within reach, a foam landing mat placed along both sides of the resident's bed.

Interview on 5/28/14 at 1:56 P.M. with direct care staff G stated the resident's fall interventions consisted of bed/chair alarm, a border mattress, fall mats, frequent visual checks of at least every two hours, a gait belt with transfers, and call light within reach when in her/his room. Direct care staff G stated she/he was not sure if the resident had a high/low bed.

Interview on 5/29/14 at 10:12 A.M. with licensed nursing staff E stated the resident's fall intervention consisted of fall mats, a new bed with a border mattress, a bed/chair alarm, non-skid sock/shoes, and a gait belt with transfers. The MDS coordinator provided the comprehensive

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F 280	Continued From page 12 care plan and the care plan was a working care plan and updated by nursing staff. Interview on 5/29/14 at 11:38 A.M. with administrative nursing staff B stated she/he completed the comprehensive nursing care plan quarterly and nursing staff revised the care plan. The revised policy and procedure dated October 2010 titled Senior Living Center Care Plans - Comprehensive revealed the comprehensive care plan was based on a thorough assessment which included, but was not limited to, the MDS. The facility failed to revise the care plan for the prevention of falls for this cognitively impaired resident with a history of a fall with fracture.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility reported a census of 31 residents. The sample included 3 residents. Based on observation, record review, and interview, the facility failed to monitor the personal alarm for 3 (#1, #2, and #3) residents sampled for falls. Findings included:	F 309		

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- The Significant Change in Status Minimum Data Set dated 3/25/14 for resident #1 revealed a Brief Interview for Mental Status score of 0 (severe impaired cognition). The resident required extensive assistance of two plus (2+) persons with bed mobility, transfers, walking in her/his room, and toilet use. The resident also required extensive assistance of one person for locomotion on the unit, dressing, personal hygiene and total dependence of one person physical assist with bathing. The resident was not steady and was only able to stabilize with nursing staff assistance with moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface to surface transfer. The resident had no functional limitations in her/his range of motion and used a walker and wheelchair (w/c) for mobility. The resident had two or more non-injury falls since admission/entry or re-entry or prior assessment.

The fall Care Area Assessment dated 3/25/14 revealed the resident required nursing staff assistance with transfers, toileting, walking, and was not safety conscious due to her/his altered thought processes. The resident was at risk for falls and had two falls. The resident had difficulty with sitting balance would bend forward at the waist. Most of the falls happened when she/he attempted to transfer self, or to walk alone. The resident had a pommel cushion (a cushion with an upward-projecting protuberance at the front part to prevent a resident from slipping down on the seat) in the w/c which kept her/him from sliding or falling forward but became strong enough to stand up beyond the cushion. Her/his ambulatory abilities vary throughout the day.

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She/he did not always use her/his walker, and had a cushioned landing pad, for falls from or by the bedside.

The revised care plan dated 4/10/14 listed the interventions nursing staff would maintain the resident's eye glasses in clean working order and provide the eye glasses to her/him daily during waking hours, family provided a bed/chair alarm and nursing staff would respond immediately to the resident's alarm when sounded, would consistently note resident's whereabouts for safety reasons, assist the resident outside when weather permitted, and provided non-slip shoes or grippers socks.

The nursing notes (NN) dated 1/16/14 at 3:45 A.M. revealed the nursing staff found the resident sitting on the floor in her/his room on her/his buttock covered in urine/stool and the floor was wet with urine. The resident's range of motion (ROM) was normal. No new redness or bruising noted. The bed alarm did not sound and a personal body alarm was obtained. The resident refused to allow nursing staff to obtain her/his vital signs and she/he denied pain or discomfort.

Record review on 5/29/14 at 9:29 A.M. lacked documentation neuro checks were initiated.

The NN dated 3/12/14 at 11:15 A.M. the activity director informed nursing staff the resident sat on the floor between a recliner and the wall. The resident had good ROM, and was able to move all extremities without difficulties.

Record review on 5/29/14 at 9:29 A.M. lacked documentation neuro checks were initiated.

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The NN dated 4/24/14 at 5:00 P.M. revealed nursing staff found the resident on the floor on her/his buttocks. The resident tried to ambulate from a recliner chair to her/his w/c, denied pain and did not grimace or guard with ROM of all her/his extremities, and no redness or bruising was noted.

Record review on 5/29/14 at 9:29 A.M. lacked documentation neuro checks were initiated.

The nursing notes and care plan revealed on 5/2/14 at 8:20 A.M. nursing staff found the resident on the floor laying on her/his right side between a w/c and a recliner. The resident complained of right arm/shoulder pain scoring a 10 (being the worst pain). The physician was notified and an order for an x-ray was obtained.

Record review on 5/29/14 at 9:29 A.M. lacked documentation neuro checks were initiated.

Observation on 5/28/14 at 1:05 P.M. revealed the resident laid in bed with the bed in the low position, a border air mattress was in place, and the call light was within reach. Direct care staff G revealed the resident laid on a white plastic alarm pad.

Observation on 5/29/14 at 7:45 A.M. revealed direct care staff F and H transferred the resident from her/his bed to wheelchair with the use of a gait belt.

Interview on 5/29/14 at 10:12 A.M. with licensed nursing staff E stated nursing staff initiated neuro checks with a fall if there were suspicions of the resident hitting their head, if the resident was unable to state they hit their head, and if a

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resident stated they hit their head

Interview on 5/29/14 at 11:38 A.M. with administrative nursing staff B stated nursing staff initiated neuro checks with falls that were unwitnessed, when the resident was unable to state if they hit their head, and if nursing staff witnessed a resident hit their head. Nursing staff should have initiated neuro checks with the fall on May 2, 2014.

The revised policy and procedure dated October 2010 titled Senior Living Center Falls, Reporting, Investigation, and Prevention revealed in the event the resident hit her/his head during the fall or the resident was unable to confirm that she/he did not hit her/his head, neuro checks would be initiated and performed by the charge nurse.

The facility failed to initiate neuro checks after unwitnessed falls for this cognitively impaired resident with a history of falls.

- Review of the Admission Minimum Data Set (MDS) for resident #2 dated 7/10/13 revealed a Brief Interview for Mental Status (BIMS) score of 5 which indicated severe cognitive impairment.

Review of the cognitive loss Care Area Assessment (CAA) dated 7/10/13 revealed the resident had periods of confusion.

Review of the behavior CAA dated 7/10/13 revealed the resident had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue),

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hallucinations (sensing things while awake that appear to be real, but the mind created), suspicion and paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking).

Review of the fall CAA dated 7/10/13 revealed the resident liked his/her independence, and did not call for help, occasionally would slip from edge of bed or wheelchair to floor. The resident did not respond well to reminders to call for or wait for help.

Review of the Quarterly (MDS) dated 4/2/14 revealed a BIMS score of 6 which indicated severe cognitive impairment. The resident was usually understood and understood others, and had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). The resident was independent for mobility, transfers, walking in the resident's room, dressing, and toileting.

Review of the nurse's note dated 5/3/14 at 11:00 P.M. the staff found the resident on the floor in front of the closet in a sitting position.

Review of the nurse's note dated 5/5/14 at 8:10 A.M. revealed the resident had 5 centimeter (cm) x 4 cm raised brownish/yellow bruise to the right forehead area.

Review of the Care Plan update for falls revealed staff failed to do neurological checks for this unwitnessed fall of a cognitively impaired resident.

Observation on 5/28/14 at 12:10 P.M. revealed the resident sat in the wheelchair with a large

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bruise noted to the right side of the face.

Observation on 5/28/14 at 3:00 P.M. the resident sat in the doorway of his/her room. A large raised area noted to the forehead, approximately one inch in elevation, with discoloration of the resident's scalp which included the area around the resident's eye area and cheek, and a large raised area noted to the right upper shin on the leg and to the ankle area.

On 5/29/14 at 8:15 A.M. the resident rested in bed with the door to the room nearly closed.

Interview on 5/29/14 at 10:12 A.M. licensed staff E stated neurological checks were initiated if a resident was unable to say they hit their head, if it was questionable with the fall and the resident was unable to state injury to head then neurological checks should be completed.

Review of the fall policy provided by the facility revised 10/10 revealed the staff were to do neurological checks if unable to determine if the resident hit their head.

The facility failed to initiate neurological checks on this cognitively impaired resident after an unwitnessed fall.

- Review of the significant change Minimum Data Set (MDS) 3.0 for resident #3 dated 7/23/13 revealed a Brief Interview for Mental Status (BIMS) score of 2 which indicated severe cognitive impairment.

Review of the Care Area Assessment (CAA) dated 7/23/13 for cognitive loss revealed the

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resident had aphasia (condition with disordered or absent language function and responded with few words).

Review of the communication CAA dated 7/23/13 revealed the resident had aphasia, dementia (progressive mental disorder characterized by failing memory, confusion with short and long term memory deficits).

Review of the quarterly MDS 3.0 dated 4/16/14 revealed a BIMS score of 3 which indicated severe cognitive impairment. The resident had unclear speech, usually understood, and sometimes could be understood by others, The resident required extensive assist of one staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The resident was not steady and able to stabilize with staff for moving from seated to standing, walking, moving off and on the toilet, surface to surface transfer, impairment on one side, and used the walker and wheelchair for mobility.

Review of the revised care plan for falls dated 5/8/14 revealed the resident was encouraged to spend time by the fireplace in recliner between meals for increased monitoring to prevent falls, staff were to continue to reposition and offer toileting every 2 hours, appropriate footwear when up and with ambulation, bed controls were moved to the bottom outside of bed, staff were to check position of the bed, and fall mats in front of toilet.

Review of the care plan update of falls dated 5/10/14 revealed staff were to attach the personal alarm so the resident could not reach and remove it, accompany the resident for toileting, decrease

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the time the resident stayed in bed, a bed alarm, encourage this (cognitively impaired) resident to use the call light, wear non-skid socks at all times, and to toilet the resident more often.

Review of the nurse's note dated 3/24/14 at 1050 A.M. revealed staff found the resident on the floor in the bathroom sitting upright with back against wall.

Review of the nurse's note dated 3/29/14 at 10:55 A.M. revealed staff found the resident lying on his/her left side with back towards bathroom and knees bent.

Review of the nurse's note dated 4/1/14 at 4:25 P.M. revealed staff found the resident on his/her left side.

Review of the nurse's note dated 4/24/14 at 5:25 P.M. revealed staff found the resident sitting on the floor in the bathroom doorway of his/her room.

Review of the nurse's note dated 4/28/14 at 8:30 A.M. revealed staff found the resident on the floor of his/her room.

Review of the nurse's note dated 5/10/14 at 11:45 A.M. revealed staff found the resident on the floor in the doorway of his/her bathroom

Review of the nurse's note dated 5/13/14 at 5:45 P.M. revealed staff found the resident on the floor, feet by the toilet and his/her head by the hinge side of the door frame.

The medical record lacked evidence neurological checks were initiated for these unwitnessed falls

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F 309	Continued From page 21 of a cognitively impaired, aphasic resident. Observation on 5/28/14 at 11:05 A.M. revealed the resident was in bed, the bed was in the low position, a fall mat was next to the bed, and a personal alarm was at the head of the bed. Observation on 5/29/14 at 11:09 A.M. revealed the resident was in bed and a personal alarm was located above the pillow at the head of the bed. Interview on 5/29/14 at 10:12 A.M. licensed staff E stated neurological checks were initiated if a resident was unable to say if they hit their head, if it was questionable with the fall and unable to state injury to head then neurological checks should be completed. Review of the fall policy provided by the facility revised 10/10 revealed the staff were to do neurological checks if unable to determine no injury to head. The facility failed to initiate neurological checks on this cognitively impaired resident after an unwitnessed fall.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
The facility reported a census of 31 residents. The sample included 3 residents. Based on observation, record review, and interview, the facility failed to provide interventions as planned for 2 (#1 and #3) residents who fell and one resident sustained a fracture.

Findings included:

- The Significant Change in Status Minimum Data Set dated 3/25/14 for resident #1 revealed a Brief Interview for Mental Status score of 0 (severe impaired cognition). The resident required extensive assistance of two plus (2+) persons with bed mobility, transfers, walking in her/his room, and toilet use. The resident also required extensive assistance of one person for locomotion on the unit, dressing, personal hygiene and total dependence of one person physical assist with bathing. The resident was not steady and was only able to stabilize with nursing staff assistance with moving from seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface to surface transfer. The resident had no functional limitations in her/his range of motion and used a walker and wheelchair (w/c) for mobility. The resident had two or more non-injury falls since admission/entry or re-entry or prior assessment.

The fall Care Area Assessment dated 3/25/14 revealed the resident required nursing staff assistance with transfers, toileting, walking, and was not safety conscious due to her/his altered thought processes. The resident was at risk for falls and had two falls. The resident had difficulty

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with sitting balance and would bend forward at the waist. Most of the falls happened when she/he attempted to transfer self, or to walk alone. The resident had a pommel cushion (a cushion with a upward-projecting protuberance at the front part to prevent a resident from slipping down on the seat)in the w/c which kept her/him from sliding or falling forward but became strong enough to stand up beyond the cushion. Her/his ambulatory abilities varied throughout the day. She/he did not always use her/his walker, and had a cushioned landing pad for falls from or by the bedside.

The revised care plan dated 4/10/14 for potential for social isolation, elopement at risk related to cognition and communication deficits, macular degeneration (progressive deterioration of the retina) and difficulty processing surrounding activities listed the interventions nursing staff would maintain the resident's eye glasses in clean working order and provide the eye glasses to her/him daily during waking hours, family provided a bed/chair alarm and nursing staff would respond immediately to the resident's alarm when sounded, would consistently note resident's whereabouts for safety reasons, assist the resident outside when weather permitted, and provided non-slip shoes or grippers socks.

The nursing notes and care plan revealed on 1/16/14 at 3:45 A.M. staff found the resident sitting on the floor of her/his room on her/his buttock covered in urine/BM and the floor was wet with urine. The resident's range of motion (ROM) was normal. The bed alarm did not sound. The intervention was for staff to replace the alarm system with the facility's personal alarm (PA) until the bed alarm was fixed.

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The nursing notes and care plan revealed on 3/12/14 at 11:15 A.M. the activity director informed nursing staff the resident sat on the floor between a recliner and the wall. The resident had good ROM, alignment and was able to move all extremities without difficulties. The alarm was off. The intervention was for nursing staff to frequently check the monitor to ensure the alarm was on.

The nursing notes and care plan revealed on 5/2/14 at 8:20 A.M. nursing staff found the resident on the floor laying on her/his right side between a w/c and a recliner. The resident complained of right arm/shoulder pain scoring a 10 (being the worst pain). The physician was notified and an order for an x-ray was obtained. The nursing intervention was for nursing staff to ensure the alarm was present and on.

The hospital radiological report dated 5/2/14 revealed an impacted fracture at the surgical neck of the humerus (right shoulder fracture).

The Progress Note dated 5/2/14 at 12:45 P.M. revealed the resident fell while trying to transfer her/himself from a w/c to a chair. The resident received a fracture of the right humeral neck and was resting comfortably in bed. The physician ordered a shoulder immobilizer and staff notified the family of the treatment and offered to send the resident to see an orthopedic. Family indicated the resident was on hospice and wanted her/him comfortable.

Record review on 5/28/14 at 3:17 P.M. revealed the February 2014, March 2014, and April 2014 Medication Administration Record (MAR) and

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Treatment Administration Record (TAR) lacked documentation nursing staff checked the resident's bed/chair alarm for function. The May 2014 TAR revealed nursing staff would check the resident's personal alarm on each shift and to start on the night shift on 5/28/14.

Observation on 5/28/14 at 1:05 P.M. revealed the resident laid in bed with the bed in low position, a border air mattress was in place, and the call light was within reach. Direct care staff G revealed the resident laid on a white plastic alarm pad.

Observation on 5/29/14 at 8:15 A.M. revealed the resident's alarm monitor was located at the nurse's station desk, switched in the off position and was verified by surveyor staff Z. At that time the resident sat in a w/c by the fireplace near the nursing station. No nursing staff were at the nursing station. At 8:20 A.M. licensed nursing staff E and administrative nursing staff B confirmed the resident's alarm monitor was switched off.

Interview on 5/28/14 at 1:10 P.M. with direct care staff G stated the resident's family provided the alarm system, nursing staff checked the alarm daily and the alarm should never be turned off. If the alarm did not sound, with an alarm check, she/he would notify the charge nurse and a PA would be used until the family provided a new alarm

Interview on 5/28/14 at 4:35 P.M. with licensed nursing staff D and confirmed by administrative staff A stated the resident's alarm was checked daily and nursing staff documented the results on the TAR.

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Interview on 5/29/14 at 8:40 A.M. with administrative nursing staff B stated staff documented on the TAR the resident's alarm check after her/his fall on May 2nd but nursing staff was not documenting the alarm checks before that.

Interview on 5/29/14 at 10:12 A.M. with licensed nursing staff E revealed the resident's alarm monitor should be on at all times and never off. The charge nurse assigned to the resident's hallway would check the alarm and documented in the computer system's TAR.

Interview on 5/29/14 at 12:30 P.M. with administrative nursing staff B stated the facility did not have a policy and procedure for PA alarm monitoring.

The facility failed to provide interventions as planned for this cognitively impaired dependent resident with a history of falls which resulted in a fracture.

- Review of the significant change Minimum Data Set (MDS) 3.0 for resident #3 dated 7/23/13 revealed a Brief Interview for Mental Status (BIMS) score of 2 which indicated severe cognitive impairment.
Review of the Care Area Assessment (CAA) dated 7/23/13 for cognitive loss revealed the resident had aphasia and responded with few words.
Review of the communication CAA dated 7/23/13 revealed the resident had aphasia, dementia with short and long term memory deficits.
Review of the CAA dated 7/23/13 for falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	C 06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 27	F 323		

revealed the resident was a high risk for falls due to partial foot amputation in the 1960's, a history of depression, an orthotic shoe for the right foot, used pummel cushion (a chair cushion with a raised area between the thighs) in the chair to discourage standing without assistance, a floor mat was next to the bed, and quarter side rail to assist with repositioning.
Review of the quarterly MDS 3.0 dated 4/16/14 revealed a BIMS score of 3 which indicated severe cognitive impairment. The resident had unclear speech, usually understood, and sometimes could be understood by others, The resident required extensive assist of one staff for bed mobility, transfers, dressing, dressing, toileting, personal hygiene, was not steady and able to stabilize with staff for moving from seated to stand, walking, moving off and on toilet, surface to surface transfer, impairment on one side, and used the walker and wheelchair for mobility.
Review of the revised care plan for falls dated 5/8/14 revealed the resident was encouraged to spend time by the fireplace in recliner between meals for increased monitoring to prevent falls, staff were to continue to reposition and offer toilet every 2 hours, and appropriate footwear when up and with ambulation, bed controls were moved to the bottom outside of bed and staff were to check position of the bed, and fall mats in front of toilet.
Review of the care plan update of falls dated 5/10/14 revealed staff were to attach the personal alarm so the resident could not reach and remove it, accompany the resident for toileting, decrease the time the resident stayed in bed, a bed alarm, encourage this cognitively impaired resident to use the call light, wear non-skid socks at all times, and to toilet the resident more often.
Review of the revised care plan and the care plan

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F 323	Continued From page 28	F 323		

update for falls lacked direction for staff on the use of a personal alarm.
Review of the medical record and the electronic medical record lacked documentation of the use or functioning of the personal alarm.
Review of the nurses' note dated 3/24/14 at 1050 A.M. staff found the resident on the floor in the bathroom sitting upright with back against wall.
Review of the fall investigations on 5/29/14 at 11:28 A.M. administrative staff B acknowledged there was lack of evidence of investigation for the fall on 3/24/14.
Observation on 5/28/14 at 11:05 A.M. revealed the resident was in bed, the bed was in the low position, a fall mat was next to the bed, and a personal alarm was at the head of the bed.
Observation on 5/28/14 at 11:39 A.M. revealed the resident sat in the wheelchair in the dining room and a personal alarm was attached to the resident's shirt and the wheelchair.
Observation on 5/29/14 at 7:30 A.M. revealed the resident sat in the wheelchair in the dining room. A personal alarm was attached to the resident's shirt on the right shoulder and the wheelchair.
Observation on 5/29/14 at 11:09 A.M. revealed the resident was in bed and a personal alarm was located above the pillow at the head of the bed.
Interview on 5/28/14 at 11:55 A.M. direct care staff G stated he/she checked the personal alarm functioning every morning but did not chart it.
Interview on 5/28/14 at 4:38 P.M. direct care staff F stated the personal alarm checks use to be on the paper activities of daily living sheet but there was not a place to document it in the electronic record.
Interview on 5/28/14 at 4:35 P.M. licensed staff P stated the staff were to check the alarm function every time a resident was transferred but not documented.

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F 323	Continued From page 29 Interview on 5/29/14 at 8:35 A.M. administrative nursing staff B stated there was not a place on the direct care staff paper flow sheet or the electronic medical record to monitor the personal alarm. The facility failed to provide a policy on the used and documentation of a personal alarm. The facility failed to document the use and functionality of a personal alarm for this cognitively impaired, aphasic resident to prevent future falls.	F 323		